STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627	A. BUILDING _____ B. WING _____	C 10/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HODGEMAN COUNTY HEALTH CENTER LTCU	809 BRAMLEY PO BOX 367 JETMORE, KS 67854

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F 000	INITIAL COMMENTS The following citations represent the findings of Complaint Investigation #KS00088946 and #KS00091782.	F 000		
F 155 SS=F	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: The facility had a census of 20 residents with 6 residents selected for sample. The sample included review of advanced directives for 4 residents. Based on interview and record review, the facility failed to have written policies in place related to advanced directives which included CPR (cardiopulmonary resuscitation). This failure	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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had the potential to affect all facility residents.

Findings included:

- The facility's investigation into an allegation of neglect on 9/10/15 included a description of an incident in which staff failed to provide CPR (cardiopulmonary resuscitation) to a resident who did not have a "Do Not Resuscitate" order. Although the investigation revealed no evidence of neglect, the facility identified an issue related to a lack of a policy related to CPR for residents who desired resuscitation in the event of being found without a pulse/respirations. The facility also identified a potential problem when they completed random interviews with staff and found that 46% of staff interviewed did not know each resident's code status or where to find that information.

During an interview on 9/30/15 at 11:00 a.m., Administrative Nurse B confirmed the facility lacked a policy related to provision of CPR prior to the 9/10/15 incident. Nurse B reported the facility developed a policy after that incident and educated all staff about the policy.

During an interview on 9/30/15 at 12:30 p.m., Administrative Staff A confirmed the facility lacked a policy related to provision of CPR prior to the 9/10/15 incident.

A policy dated 9/21/15, 11 days after the incident when staff failed to initiate CPR, included, "...If resident is a FULL CODE, CPR is to be started, begin CPR - transfer to ER [emergency room] per cart the notify family, notify physician..."

The facility failed to have written policies in place

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F 155	Continued From page 2 related to advanced directives which included CPR. This failure had the potential to affect all facility residents.	F 155		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 20 residents with 6 residents selected for sample. The sample included review of choices for 3 residents. Based on observation, interview, and record review, the facility failed to allow 2 of 3 residents the right to make choices about their daily care as related to bathing frequency. (#2, #3) Findings included: - Resident #2's clinical record included a 10/10/14 Annual MDS (Minimum Data Set) that identified the resident with no cognitive impairment, the need for assistance of one staff for bathing, and the resident's identification it was "very important: to choose between tub bath, shower, bed bath or sponge bath." The 10/15/14 CAAs (Care Area Assessments) included: *ADLs (activities of daily living): Noted resident	F 242		

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#2's independence with all ADLs except bathing and application of stockings to aid in prevention of swelling of the lower legs. According to the CAA, the resident needed minimal supervision with bathing.

The 7/13/15 Quarterly MDS identified resident #2 with no cognitive impairment and assistance of one staff for bathing.

The care plan included the 5/7/14 intervention, "Bathe/shower twice a week and prn [as needed]. Bath days are Monday and Thursday..."

The "Bath/Shower Schedule" directed staff to assist resident #2 with bathing twice a week on Mondays and Thursdays.

During an observation on 10/1/15, resident #2 moved about the facility in a wheelchair. The resident had no signs of cognitive impairment and had the ability to verbalize his/her needs.

During an interview on 9/30/15 at 2:10 p.m., resident #2 reported staff assisted him/her to bathe twice a week. According to the resident, staff did not ask how often he/she wanted to bathe, but instead told him/her they would provide bathing twice a week.

During an interview on 10/1/15 at 11:30 a.m., Social Services Staff C reported he/she asked residents about the type of baths they preferred (showers, bed baths, sponge baths, tub baths) at least once a year. According to staff C, he/she did not ask the residents about their preferences related to bathing frequency. Staff C reported he/she told residents staff would put them on a schedule for two baths per week.

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During an interview on 10/1/15 at 1:50 p.m., Administrative Nurse B reported all residents "typically" received two baths per week. Nurse B confirmed staff did not routinely ask residents their preferences related to bathing frequency.

According to the facility's "Resident Rights" policy, residents had the right to plan their daily schedules.

The facility failed to offer resident #2 the right to make choices related to bathing frequency.

- Resident #3's clinical record included a 9/19/15 Annual MDS (Minimum Data Set) that identified the resident with moderate cognitive impairment, the resident's identification it was "very important: to choose between tub bath, shower, bed bath or sponge bath ", and the need for extensive assistance of 1 staff for bathing.

CAAs (Care Area Assessments) dated 9/22/15 included:
*ADLs (activities of daily living): Noted the resident's need for limited assistance with all ADLs except eating.

The 6/21/15 Quarterly MDS identified resident #3 with no cognitive impairment and the need for extensive assistance of one staff for bathing.

The 8/20/13 Care Plan directed staff to bathe resident #3 twice a week and as needed.

During an observation on 9/30/15 at 3:00 p.m., resident #3 sat in a chair in his/her room with a walker next to the chair. The resident had no evidence of cognitive impairment and had the

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F 242	Continued From page 5 ability to communicate his/her needs verbally. During an interview on 9/30/15 at 3:00 p.m., resident #3 reported he/she bathed daily prior to admission to the facility, and bathed twice weekly. According to the resident, staff did not offer him/her choices related to bathing frequency. During an interview on 10/1/15 at 11:30 a.m., Social Services Staff C reported he/she asked residents about the type of baths they preferred (showers, bed baths, sponge baths, tub baths) at least once a year. According to staff C, he/she did not ask the residents about their preferences related to bathing frequency. Staff C reported he/she told residents staff would put them on a schedule for two baths per week. During an interview on 10/1/15 at 1:50 p.m., Administrative Nurse B reported all residents "typically" received two baths per week. Nurse B confirmed staff did not routinely ask residents their preferences related to bathing frequency. According to the facility's "Resident Rights" policy, residents had the right to plan their daily schedules. The facility failed to offer resident #3 the right to make choices related to bathing frequency.	F 242		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		

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systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 20 residents with 6 residents selected for sample. Based on interview and record review, the facility failed to maintain accurate medical records for 1 of 6 records, including the complete assessment of the resident's physical condition at the time staff found him/her without a pulse and respirations and the rational for why staff did not initiate CPR (cardiopulmonary resuscitation) as directed by physician's orders. (#1)

Findings included:

- Resident #1's clinical record included a 4/28/15 Admission MDS (Minimum Data Set) that identified the resident with moderate cognitive impairment, and no diagnoses/condition that resulted in a life expectancy of less than 6 months.

CAAs (Care Area Assessments) dated 4/28/15 included:
*Cognitive Loss: "...has a history of a neuroendocrine tumor [a tumor that produces/secretes hormones] and has opted to have no surgery at this time..."

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Resident #1's 6/22/15 included, "...is a full code- [he/she] is to be resuscitated..."

On 4/20/15, resident #1 signed a document that included, "I do not want a Do Not Resuscitate order." According to that document, the resident desired CPR (cardiopulmonary resuscitation) in the event staff found him/her without a pulse and without respirations.

Physician's orders signed 7/8/15 included, "Resident is full code- is to be resuscitated."

Nurse's notes included the following entry written by Licensed Nurse D:
*9/10/15 at 1:18 a.m.: "Found without lung or heart sounds, cool to touch, cooperative at 2300 [11:00 p.m.] bed check and breathing at 0000 [midnight]." The note written by Nurse D lacked rationale for why staff did not initiate CPR as per resident #1's wishes.

During an interview on 10/1/15 at 4:05 p.m., Licensed Nurse D reported he/she worked as the charge nurse on the night of 9/10/15 when staff found resident #1 without a pulse/respirations. Nurse D reported he/she knew the resident did not have a DNR (do not resuscitate order) at the time staff found the resident, but described resident as "obviously gone" by the time staff found him/her. Nurse D described resident #1 with stiffened extremities, a pale/yellowish skin color, eyes partially open with fixed pupils, and cool to the touch when he/she first entered the room at 1:18 a.m. on the morning of 9/10/15. According to Nurse D, the stiffness of the resident's arms made placement of a blood pressure cuff difficult. The resident lacked a blood pressure, respirations, pulse at the time of Nurse

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F 514	Continued From page 8 D's initial examination at 1:18 a.m.. Nurse D confirmed his/her documentation in the clinical record lacked the descriptions of resident #1 as described in this interview, including the nurse's rationale for not initiating CPR. Although requested, the facility did not provide a policy related to documentation in the medical record. The facility failed to maintain accurate medical records for resident #1, including the complete assessment of the resident's physical condition at the time staff found him/her without a pulse and respirations and the rational for why staff did not initiate CPR as directed by physician's orders.	F 514		